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ABSTRACT

This document reports on the results of the Latino Task Force, chartered for the purpose of identifying the mental health problems of the Latino community, identifying potential causes and evaluating the relevance and effectiveness of existing mental health services, in order to formulate viable recommendations for community mental health research and training. Topics focused on are: the sources and nature of Latino problems, Latino social structure, the influence of cultural conflicts and oppression on mental health, Latino psychic structure, present-day mental health service delivery systems, professional personnel and indigenous resource personnel staffing procedures, inservice training, reorientation of mental health professions, alternative training methods, curriculum, research, and accreditation. The report concludes with a set of recommendations for training of personnel that would establish an effective mental health service program, staffed with empathetic professional, paraprofessional, and indigenous personnel trained to cope with Latino mental health requirements in a nonstress producing environment. (Author/AM)

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LATINO COMMUNITY MENTAL HEALTH

By

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PREFACE

The community mental health movement has a long and highly dispersed history. It is an idea whose time has come. Yet, it is still in its nacent stages of institutionalization. Critical to the evolving success of the community mental health movement are two factors: First, the youth, but ever-increasing maturity and intellectual strength, of the social sciences. Second, the concomitant technological developments which have made it possible for ever-increasing proportions of the population to have an increasing measure of participation in the processes of decision-making that affect their own lives.

The social science literature abounds with empirical studies that establish the great explanatory import of social class in the analysis of incidence of mental illness, rates of admission to mental health facilities, and type of treatment administered. The technological revolution in communications has brought a higher degree of awareness of how social, political, and economic institutional arrangements in society set up structural pressures affecting the mental health of the general population. What started as a philosophical perspective in the nineteenth century gradually was transformed by social science into an empirically verifiable knowledge base of increasing depth and breadth in the twentieth century. In the post-World War II era, the movement gathered considerable strength as a set of empirically based perspectives, but was not part of the institutional structures by which this society dealt with mental health. On February 5, 1963, in an extraordinary message to congress, President John F. Kennedy called for a new approach to mental health care in the United States. The resulting Community Mental Health Act both focused and legitimated the disparate streams of the community mental health movement and set in motion processes for its institutionalization.

While there is no exact and technically precise definition of what is still an evolving concept of "community mental health," it can be differentiated from the traditional, exclusively *medical* approach to mental health by four of its major characteristics. First, the community mental health move-

ment seeks an empirical, research-based understanding of the interconnectedness between the family, community, social, economic, and cultural structures, as well as biological and psychic structures, as sources of pressures that directly affect the mental health of individuals. Second, the community mental health movement seeks to promote an improved general state of mental health through intervention techniques in which the recipients of health care have had a measure of knowledge of and participation in the processes of development and implementation. Third, the prime objective is positive and preventive, in that it seeks to promote and maintain *health* rather than to possess an exclusive concern with the treatment of *illness* that has become too great to be ignored. Fourth, the target of the community mental health movement is the entire population of a defined community and not simply those individuals whose mental condition has become so acute as to be identified as mentally ill. In this volume we attempt to apply these concerns to the Latino community of the United States (Chicano, Puerto Rican, and other U.S. ethnic populations of Indian, Spanish, and Latin American heritage) with the explicit objective of making recommendations that may be implemented into public policy.

The present volume is an outgrowth of the National Interdisciplinary Conference on Community Mental Health Training which occurred at the Center for Tomorrow, Cleveland, Ohio, in May 1973. The conception of a conference, the purpose of which would be to encourage an interdisciplinary and multidisciplinary approach to community mental health grew out of Dr. Bernard Bandler's work as Director of the Division of Manpower and Training Programs of the National Institute of Mental Health. The division staff work conceptualizing interdisciplinary and multidisciplinary approaches to training for community mental health work resulted in a grant to Dr. Israel Zwerling of the Albert Einstein College of Medicine in 1971. In keeping with the egalitarian and participatory emphases of the community mental health movement, Bandler and Zwerling turned over direction of preparation for the conference to a Steering Committee, the first meeting of which took place in September 1971; members served without com-

pensation. In addition to representatives from a variety of relevant disciplines, the Steering Committee included non-credentialed and "new careerist" *community* representatives (all of whom were Black). Task forces were created to investigate and produce reports in seven different areas: delivery of health care service, training, continuing education, racism, training evaluation, community participation, as well as social-cultural factors affecting mental health.

The following two years were marked by monumental conflict in perspectives and action priorities of the highly heterogeneous members of the Steering Committee. As work progressed, it became apparent that the Steering Committee itself reflected many of the deleterious effects of professionalism, elitism, and racism characteristic of the general society. The Steering Committee did not have any non-credentialed or new careerist (let alone any professional) representatives from the Latino community, which constitutes the second-largest ethnic population in the country. Because the task force on racism in community mental health training adamantly insisted on an exclusive focus on the Black Experience (due to the magnitude of that task), the Steering Committee recommended formation of an Ad Hoc Committee to review the report of that task force and consider preparation of a small, complementary statement pertaining to the experience of Latinos in the United States.

In May 1972, eight months after the formation of the Steering Committee, as if in an afterthought, Ivette Trinidad, a Puerto Rican, and Rodolfo Alvarez, a Chicano, were invited to become members of the Steering Committee and to co-chair the Ad Hoc Committee on Latinos. These appointments led to a new dimension of conflict within the Committee. The pressure resulting from these appointments led, in October 1972, to changing the status of the Ad Hoc Committee to a full-fledged and budgeted task force on community mental health training for the Latino community. Ivette Trinidad did not attend any further Steering Committee meetings and finally resigned in March 1973, charging the Committee with racism and elitism. She decided to continue as co-chairperson of the Latino task force and attended its first two meetings,

where she made valuable contributions even though she was unable to attend further task force meetings; nor was she able to attend the actual National Conference in May 1973.

The Latino Task Force on Community Mental Health Training went on to develop a major analysis and policy statement on the community mental health needs of the Latino community which was presented to the National Interdisciplinary Conference on Community Mental Health Training in May 1973, where it underwent a critical review along with the reports of each of the other seven task forces.

A word is in order about the composition of the Latino task force, how it conducted its work, and its impact on the Steering Committee and the National Conference. Members of the task force were appointed by the mutual agreement of the co-chairpersons with the attempt to achieve broad geographic distribution across the country and about equal representation of Puerto Ricans and Chicanos. Including the chairpersons, ten people were originally invited to participate; because of heavy commitments elsewhere, two persons asked to be relieved, and, due to the pressure to pursue our task expeditiously (to make up for lost time in comparison to other task forces), only one was replaced. Thus, the final composition of the task force consisted of five Chicanos, three Puerto Ricans, and one "white" with considerable experience working in both Puerto Rican and Chicano communities. A Chicano member of the task force had considerable experience working in Puerto Rican communities in New York; likewise, a Puerto Rican member had considerable experience working in Chicano communities in California. The group was therefore well equipped, both by personal background and work experience as well as by professional training, to carry out the study which resulted in the present volume. It did this in several ways. First, it got together for very intensive two-day meetings five times in the ten-month period following the creation of the Latino Ad Hoc Committee in May 1972. Drawing from their own rich experience, task force members outlined and segmented the task ahead and assigned each other specific objectives. Our explicit purpose was to bring together two areas of collective endeavor in a manner that would result in constructive recom-

mendations for Latino community development pertaining to mental health. These two areas were the world of scholarship and the world of community experience. We agonized over what non-Latino professional colleagues would think of a report written in the idiom of the barrio and the ghetto just as much as we agonized over what members of our ethnic communities would think of a report written in the abstracted jargon of the professions and academic disciplines. The resulting volume, we hope, presents a middle ground wherein professionals and community residents can begin to communicate their not necessarily incompatible concerns to each other for the common purpose of developing a higher standard of Latino community mental health.

We proceeded in our work by constantly returning to a dialogue with members of our communities for an exploration of needs and perceptions of difficulties in the life-space they occupy in this society. Similarly, we drew [illegible] our own life experience both as members of our ethnic [illegible]mmunities and as clinicians and scholars. As our work progressed, we attempted to implement our evolving perspectives. One member of the task force, Roberto Mejia, was added to the Steering Committee, where, with two Latino proponents, pre-national conference planning and post-conference strategy sessions took on a decidedly more sensitive account of the nation's second largest ethnic minority. The National Conference itself was attended by a number of Chicano and Puerto Rican community representatives whose names were recommended by members of the task force. These representatives and the task force members played a critical role at the National Conference by reviewing the work of other task forces and participants with an eye to insuring that recommendations made would be compatible with the community mental health needs of the Latino community.

At the conclusion of the National Conference, the Steering Committee created an Editorial Committee, to be chaired by Israel Zwerling, for the purpose of consolidating the work of the task forces and the National Conference into a major publication suggesting new directions for community mental health training. The Editorial Committee consisted of Israel

Zwerling, chair, Rodolfo Alvarez, Ruth Batson, Leon Finney, Jr., Paul Parks, and Forrest Tyler. The Editorial Committee and staff worked from May 1973 through the summer of 1974 to carry out its mission of consolidating the inputs from the National Conference and task forces. The Steering Committee then determined that the major publication produced by the Editorial Committee should also contain all of the task force reports. Additionally, the Steering Committee determined that publication of the Editorial Committee's work should not preclude the independent publication of their reports by each of the task forces. In fact, the Steering Committee encouraged each task force to publish its own report independently so as to achieve the maximum possible distribution and public policy impact.

The present volume is the report of the Latino Task Force on Community Mental Health Training to the National Interdisciplinary Conference on Community Mental Health Training. It is copyrighted by the task force, which is especially grateful to Martha Lopez and Victor Velasquez for their editorial assistance; Norma Hill, Olivia Rodriguez, and Lucile Sangouard for clerical assistance.

This volume is published as Monograph Number One by the Spanish Speaking Mental Health Research and Development Program, Rodolfo Alvarez, Principal Investigator, University of California, Los Angeles, California 90024, in the interest of achieving the broadest possible distribution of the ideas and recommendations contained in the report. Copies may be obtained at cost from the principal investigator. The Spanish Speaking Mental Health Research and Development Program supports a number of research and publication projects on the social-class correlates of Chicano community mental health with potential relevance to public policy formation. The SSMHR&D Program is funded by USPHS Grant 5-R01-MH24854 from the Center for Minority Mental Health Programs, Dr. James Ralph, Chief; National Institute of Mental Health, United States Department of Health, Education and Welfare.

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I. PURPOSE

The Latino Task Force on Community Mental Health Training was chartered for the purpose of identifying the mental health problems of the Latino community, identifying potential causes, evaluating the relevancy and effectiveness of existing mental health services in order to formulate viable recommendations for community mental health research and training.

The results of this study are embodied in this report, which is concluded with a set of recommendations for training of personnel in order to establish an effective mental health services program for the Latino community. This program would entail staffing with empathetic professional, paraprofessional, and indigenous personnel trained to cope with Latino mental health requirements in a non-stress-producing environment. Recommendations for continued training, accreditation and research are made in recognition that these types of personnel are the backbone of effective preventive and remedial health care for the Latino community.

II. SOURCE AND NATURE OF LATINO PROBLEMS

The stress of racial discrimination, poverty, and substandard housing, resulting in cultural and personal identity conflict, high rate of delinquency and school drop-out make it clear that Latino community mental health needs are great. It is also obvious that Latinos do not make extensive use of mental health facilities. The most logical explanation for this may be the irrelevance of these current services to their needs. It therefore behooves mental health officials to become aware of these grave shortcomings prior to expecting Latinos to use facilities. Despite the fact that the overwhelming majority of Latinos suffer under conditions which threaten their community mental health, it is well known that Latinos use mental health facilities less frequently than do other groups:

> . . . disproportionally few Mexican Americans arrive at the psychiatric clinic. Of those who do contact the clinic a disproportionate number drop out after brief contact.[1]

Torrey, on the basis of his research, describes the Latino dilemma:

> Based on need, one would expect Mexican Americans to over-utilize mental health services rather than under-utilize them. Their need is indicated by such stress indicators as the number of juvenile delinquent referrals, welfare recipients, and neglected and dependent children, all of which are disproportionately high for the Mexican American parts of San Jose. One predominantly Mexican American school district has proportionately six times as many children in mental retardation classes as a solid Anglo school district. One would also expect Mexican Americans to have a disproportionately high incidence of mental illness since many of them are poor and since many are undergoing acculturation . . .
>
> Looking at utilization rates, a survey of patient visits to the Central Center during 1968 showed only 4% to be Mexican American. This is under half of what would be expected. Even the "East Valley Center" opened specifically to improve services for Mexican Americans, had only 11% of patient visits by them during its first nine months. A similar underutilization of both inpatient and outpatient psychiatric facilities by Mexican Americans has been shown in Los Angeles.[2]

Theoretically, in terms of need, Latinos should be overutilizing mental health services, but instead are dropping out at an alarming rate. Burruel and Chavez give their conclusion: "It simply means that Mexican Americans do not consider available mental health services as helpful in meeting their needs."[3]

III. LATINO SOCIAL STRUCTURE

Along with distinct cultural values, the Latino community also has its own unique social structures, which are not taken into account by service institutions. The result is that services which ignore or conflict with Latino social-cultural structures are not used.

Mental health delivery systems must not only take into account the cultural values of Latinos; they must go further. They must be organized around the strengths and assets of Latino culture, e.g., values, extended families, language, sense of collectivity, cognitive and perceptual styles, etc. These must

be acknowledged as positive forces in the delivery of services, just as they have been the foundation of our strength and survival as a people in the midst of an oppressive pecuniary and alien culture.

One example of the role of the Latino social and cultural structures that should be taken into account in designing mental health services is described by Burruel and Chavez:

> Many Mexicans continue to uphold the traditional family function of solving their own problems. They believe in protecting and caring for the troubled family member rather than sending him to the Anglo clinic or hospital for treatment, which may be interpreted as a form of rejection.[4]

IV. KEY FACTORS WHICH INFLUENCE LATINO MENTAL HEALTH

A. Cultural Conflicts

The awareness on the part of the Latino that our community mental health is directly related to cultural conflict has been articulated by Latino community scholars and leaders.[5] For example, Puerto Ricans have observed the following as causes for socio-emotional conflicts:

> The impact of the cultural dislocation attendant on migration is the source of grave inter-generational conflict within Puerto Rican families and is producing considerable confusion and insecurity among Puerto Ricans of all ages who find themselves imperfectly integrated in each of two seemingly incompatible systems. Unless concrete steps are taken to structure the migrant's experience in the city in a way that builds on his culture instead of destroying it, he is likely to remain permanently locked in a position of disadvantage with respect to jobs and education.[6]

Evidence from field research is beginning to accumulate, though at a rate that mental health professions must expedite. It was found that the most significant factor in failure of educational achievement among Mexican American boys in California was the value conflict between the curriculum and the teacher and Mexican American boys.[7]

Castañada formulates the concept in different terms:

> Differences in learning, incentive-motivational, communication, and

human relational styles between members of different ethnic groups are the result of socialization practices reflecting the values of these groups. Institutions which have followed the exclusionist melting pot philosophy have favored that set of styles characteristic of the American middle-class. Hence, many people in this country have been denied academic, economic and social success. Educational programs which are not based on the unique learning, incentive-motivational, human relational and communication styles of the people they serve do not provide culturally relevant learning environments and are culturally undemocratic. They reject the individuality of their students to question the values and learning experiences which have acquired in their homes and neighborhoods. The results of these insensitive practices are reflected in school drop-out rates and in the low levels of educational attainment of members of minority groups.

It is clear that the exclusionist melting pot ideology has created a conflict of values in our schools which has inevitably led to the belittlement of the values and life styles of members of certain ethnic groups. Schools are too often institutions of acculturation rather than of education. If we are to eliminate these undemocratic practices and ensure that educational institutions respect cultural differences evident in our society, we must encourage the adoption of a new philosophy, that of cultural democracy. The right of each individual to be educated in his learning, incentive-motivational, communication and human relational styles must be explicitly acknowledged.

This implies that the individual has a right to maintain a bicultural identity, that is, to retain his identification with his ethnic group while he adopts mainstream American values and life styles. He will not be forced by the institution to abandon loyalty to his ethnic group in order to succeed academically or economically.[8]

B. Oppression

Our own professional and clinical observation leads us to conclude that systematic oppression results from the economic and political subordination which places Latinos in a psychically untenable situation; thus creating the propensity for mental illness.

For example:

Individual success in adaptation outside the Puerto Rican milieu and the pressure of mainland prejudice and invidious stereotyping led some Puerto Ricans to disassociate themselves from the ethnic community. Much has been made in most of the commentaries, anthropological and journalistic, about New York Puerto Ricans, of the fact that some

> Puerto Ricans call themselves "hispanos" in certain circumstances. This is taken usually as evidence of the readiness of Puerto Ricans to mask their shame-laden origins even through such transparent circumlocution. No doubt such evasions reflect some insecurity and self-hatred that psychologists tell us afflict individuals who experience prejudice derogation or inferior status over long periods.[9]

The Mexican American child, ridiculed at school,

> . . . soon questions his actual worth as a person; his self-confidence becomes imparied; he soon resorts to protective devices—the pecking order, one could say, in which if a person is humiliated he seeks someone to humiliate in turn. The obvious object is family and community.
>
> So confusion and doubt of self, with all its disquieting features, projects itself on those responsible for causing him to be different, guaranteeing that he would incur ridicule and rejection. Obviously, his parents are partially guilty; surely, the community as well, if made up mostly of Chicanos, because he feels a sense of shame of self, and they too become valid objects of his projected self-hate and identity denial.[10]

Oppression dehumanizes an individual and his group. However, this process is never fully completed, for a man cannot psychiacally accept the status of a non-human.

Dehumanization is attempted through the invalidation of the Latino's culture, and thus his group as a whole. It is an attack upon the core of his being, and he responds defensively.

On the one hand, he cannot accept the status of a non-person, and on the other, he cannot accept the invalidation of the core of his "sanidad mental," his culture. Thus, he refuses to be "socialized" exclusively into the dominant cultural structure. He refuses to reject his culture, values and norms, for to reject the culture is to reject the self. If he succumbs to being socialized, compensated, and "caseworked" into accepting the blame for his oppression, he can be socially, politically, and economically controlled. Methods range from psychiatric "invalidation" of those who have refused to be socialized, as described by Thomas Szasz, to the "early childhood" programs in the schools, that will attempt to remove children at a very young age from the influences of their families and cultural values. Children who refuse to be socialized (because they cannot accept the blame in the first place, and see no benefit

for themselves in the socialization process) will be labeled "disruptive," "emotionally disturbed," and dealt with in ways that deny their humanity.

The Latino refuses to reject his culture simply because, he has observed the values and norms of the Anglo for centuries, and in terms of human morality and ethical considerations, finds them wanting. Centuries of contact with the dominant society have taught us that even when individuals attempt assimilation, the benefits of participation and inclusion into society are not forthcoming equally to us in comparison with the Anglo individual.

The Latino is not accepted on his own cultural terms, and cannot be assimilated into a racist society; thereby resulting in the situation described by R. D. Laing:

> The experience and behavior that gets labeled schizophrenic is a special strategy that a person invents in order to live in an unlivable situation.[11]

The relationship between poverty and racism vis-a-vis the dominant Anglo group can be viewed in terms of cultural differences. It must be discovered whether the definition of deviance, when applied to the Latino by the community mental health worker, is objective, or whether it is a function of those in "power."

Racism as a pathological force which permeates the dominant Anglo culture and which contributes to illness within the Latino community, must be identified in a clearer perspective.

What the dominant society, and, in particular, Anglo social scientists, fail to understand is that, in the face of this attack on himself and his culture, the Latino can only respond in behavioral ways which are familiar to him. Thus, what occurs is that under the threat of personal and cultural invalidation, and under the oppression of exclusion and rejection, which prevent him from realizing himself as a person with dignity (being relegated to menial non-productive jobs, ghetto housing—in short, socio-emotional castration of his manhood), the Latino man's only means to compensate is to over-compensate. He manifests an extreme caricature of the male norms

of the Latino culture—extreme assertion of himself, womanizing, "parrandiando" boasting, "andar con la palomia", alcoholism, etc.

This extreme caricature is termed by mental health professionals as *the Machismo* norm of the Latino culture; which is a misunderstanding of Machismo. Such extreme behavioral caricatures of Latino cultural values and norms is labeled as maladaptive by social scientists. For Anglo scientists to assume that this behavior is normative behavior of the male in the Latino community is cultural imperialism at best! Yet this is exactly how Anglo mental health professionals operate amongst the Latino. They study him, find the manifestations of distorted and dysfunctional cultural norms, and return to blame the victim by invalidating him and invalidating his culture.

V. LATINO PSYCHIC STRUCTURE

The Latino psychic structure must be understood as having its *own* roots in its historic interplay and place of origin. The way of life of the twentieth-century Latino reflects two main elements that make up his personality and culture.

First is the "indigenismo" derived from the geographic proximity of Puerto Rico and Mexico to the USA which results in the continuous recharge of cultural identity.

The second element is the influence of the European and North American Anglo dominant elements.

The community mental health worker must be made aware of the salient cultural values and norms which play an important part in shaping the personality of the Latino, such as:

1. Concepts of "la familia, el respeto, el honor";
2. The support offered by the Latino family during periods of stress as a positive coping mechanism;
3. Feelings of "envidia, celos, sustos, mal de ojo" which can be understood only within the context of the Latino world;
4. The use of the Spanish language and the fact that different groups of Latinos have different vocabularies and

dialects; psycho-linguistics;

5. Sex roles which differ for the Latino and must be understood in their proper cultural context;
6. The differences in cognitive style—field independent versus field dependent modes of learning, which are culturally based, and which affect school behavior of children;
7. The cultural frames of reference which undergird the Latino's behavior.

VI. PRESENT-DAY MENTAL HEALTH SERVICE DELIVERY SYSTEMS

Bi-cultural Latino mental health workers have become alarmingly convinced that traditional Anglo mental-health services produce socio-cultural and psychic disequilibrium (stress) for Latino consumers. This is so because the overwhelming majority of Latinos who seek mental health services live within Latino value systems and within the socio-cultural "barrio" systems.

It is in relation to this Latino monocultural majority that traditional Anglo mental health systems must be adapted. The bi-cultural Latino, usually professional or paraprofessional, who is able (however precariously) to walk the psychic tightrope of bi-culturalism must be given great institutional support with which to serve the Latino community.

Thus, the attempts to use traditional Anglo therapies and service delivery modes cause additional emotional stress in the Latino client and ensures a disproportionate rate of drop-out and non-use by Latinos.

> We Chicanos have experienced social work practice principally as an extension and application of Anglo American conquest involving the invasion, division, manipulation and suppression of our culture. Its promise to contribute to our freedom and development remains unfulfilled.
>
> Social work practitioners have tended to penetrate the cultural context of our people, with little respect for our culture. They have imposed their own view of the world upon us whom they have invaded. They have attempted to repress our creativity, curb our genius, and

control our cultural expression by offering us societal rewards and punishments for pre-approved and pre-disapproved attitudes and behaviors . . . they continue to collaborate in attempting to extend the scope of (Anglo) domination to our cultural life . . . they have treated us as "immigrants" and "aliens" . . . Their actions constitute acts of violence against the cultural integrity and freedom of our people.[12]

These shameful findings lead Torrey to conclude, as most Latino professionals have concluded, that:

Traditional mental health services are inextricably bound to the dominant, ruling caste of Anglos in the minds of Mexican Americans. Although this overlaps both the distinctions of class and culture . . . it differs in implying a more rigid segmentalization of society with hereditary positions of dominance and submission. These positions implicitly are part of the divine order and dictate such things as social intercourse and occupation as well as the use of mental health facilities. Caste goes beyond income level and value systems; it is the Order of Things.

Inevitably the mental health facilities set up by the Anglo caste become associated with perpetuating this order. A widely-circulated story in the Mexican American community concerns the fate of three Mexican American county employees who went to Washington for the Poor People's march. Upon their return they were ordered to have psychiatric examinations by their superiors. It is also common for the Welfare Departments to order psychiatric examinations for recipients to get them classified as psychiatrically disabled and thus off the general welfare roles. If they refuse their check is withheld. Little wonder that for Mexican Americans psychiatry is looked upon as just one more way to degrade them.[13]

Diagnostically, the behavior of the Latino people can only be understood from their bicultural/bilingual perspectives. A realignment of the parameters within which health and illness are defined must be developed to provide a flexible context in which differences in the conception of mental health from alternative cultural perspectives can be reasoned out. The concept of culture conflict awareness is beginning to be professionally tested out and validated in various mental health centers.

The Latino Mental Health Outreach Program, which serves the 90,000 Latinos in Detroit, although not originally designed to test the concept of cultural conflict, learned very early that

cultural conflict was a key factor in mental health:

> It was the conviction of the Latino Mental Health Task Force, in initiating this program, that cultural factors would be of great importance in successfully delivering mental health services to Latinos. After months of operation, we have found the above to be even more significant than expected.
>
> It became obvious in the first few weeks of providing services that Latino families who are having social and mental health problems all have experienced or are experiencing serious difficulties that result from their encounter with a dominant culture that is different and in many ways incompatible with their own.
>
> The increasing social pressure of the dominant culture toward nuclear family organization, and increased mobility among the young has deprived many of our elderly citizens of the family life they expected to grow old with. The economic, health and housing problems that result are obvious. Less well recognized are the mental health problems that result from loneliness and uselessness for people whose culture dictates that age should bring more grandchildren to care for, more useful tasks to perform, and the respect and love of a larger and larger family circle.[14]

This community-run program is beginning to deal with the need for new perspectives on mental health for our community. Further development along these lines is required.

A. Service Delivery Systems Recommendations

Community Mental Health Service Delivery Systems must be designed to insure non-stress-producing utilization by the Latino community.

1. **CMH facilities should house Latino Advocate Branch Offices of all major public service institutions so that maximum efficiency and co-ordination of service can be rendered to the Latino community. The police, school, public health and other staff personnel of these branch offices must be trained for service delivery to the Latino community.**
2. **CMH facilities should include workers trained in organizing techniques which have proved effective within the Latino community to insure the continuing implementation of Latino values in the design of service delivery systems.**
3. **Community mental health systems must utilize techniques for identifying social and cultural conflicts (between the Latino community and the dominant society) which produce**

Latino clients.

4. **CMH services must incorporate Latino values and be rendered in settings which reflect Latino socio-organizational reality: in the home, in voluntary associations, at places of employment, etc.**
5. **CMH services must be compatible with and supportive of Latino social and cultural structures: extended family, religion, folk medical practices, etc.**

B. Additional Service Delivery Systems Recommendations

1. Accessibility
   a. Locate mental health service facilities within the Barrio.
   b. Establish hours and days of service that meet the needs of the community.
   c. Provide extensive field services in addition to centralized office services.
   d. Use Mental Health literature terminology that is less technical and more literal in meaning to the Spanish-speaking client.

2. Structure
   a. Offer mental health service delivery systems which are flexible rather than prestructured; collegial rather than bureaucratic.
   b. Abandon the practice of seeing clients by appointments only.

3. Program
   a. Cause the delivery systems to take into account the economic, political, and cultural oppression of the Latinos by the dominant society by offering multi-service programs with crisis intervention as an important component.
   b. Make social action, community organization and advocacy services intrinsis to every delivery system.
   c. Include as part of the mental health delivery systems the badly needed services for drug addicts and alcoholics.
      (1) Addict and alcoholic programs must be specially designed for the Latino addict or alcoholic, in the context of his culture.
      (2) The programs must provide opportunities for the ad-

dict or alcoholic to be economically and politically involved in social action within the barrio.

4. Treatment
   a. Include the use of family, compadrazgo networks, and barrio support systems as key elements of the treatment process.
   b. Characterize the relationship between client and mental health workers "personalismo", not "professional*ism*."

5. Parallel Delivery Systems
   a. Existing mental health delivery systems which are supposed to serve el barrio must involve the Latino community in the development of parallel delivery systems to relate specifically to the culture-conflict theory.

VII. STAFFING PROCEDURES

A. Professional Personnel

It is essential that mental health service delivery systems within the "barrio" be administered and staffed by bilingual and bi-cultural mental health workers.

> The cultural identity of the helping facility is a key issue in its utilization by the Chicano population. When the facility is removed from the local community, when it is staffed by members of other ethnic groups, and when the language spoken is English, many of the residents in Chicano communities would rather continue with their problems than face what they perceive to be the humiliation of a hostile environment.[15]

Obviously, a therapeutic relationship is impossible if the helper and the client do not speak the same language. Yet mental health programs in our "barrios" have few fluent Spanish-speaking staff, and virtually no bi-cultural staff.

> When Chicanos are on the staff of these facilities they are usually in low level "community" positions and are relegated to the status of interpreters for the "professional." The result is that the design, control and major portion of the therapeutic relationship is not in the hands of people who know the Chicano population best. While language barriers in communication are the most obvious, there are many other aspects of the communication process of which a helping

person must be aware. These range from different communicative styles such as body positions, facial expressions and body contact, to different ideas, beliefs and conceptions of problems, community, family and normality.[16]

To be utilized and to be effective in offering mental health services the facility must reflect in its staff composition, a Raza Latina identity.

The criteria for selection of staff in mental health facilities, dominated by Anglo professionalism, have been heavily weighted with consideration of credentials, with little consideration for personal and experiential qualifications. The result has been that Latino mental health workers, in order to move into meaningful staff positions, are under pressure to "qualify" professionally at the expense of their cultural sensitivity and their community roots. Meaningful staff selection criteria must include the following:

1. Sensitivity to the Spanish-speaking community and familiarity with the make-up of the community to be served.
   a. Knowledge of the language, the religion, the age and sex distribution.
   b. Knowledge of the dominant practices, values and folkways.
   c. Knowledge of the type of generational groups to be served.
   d. Knowledge of the variances found in living conditions, types of dwelling (public housing, owner, renter, slum, residential).
   e. Knowledge of the social and emotional problems encountered in the area.
   f. Geographic and/or socio-economic mobility.
2. Understanding of the different perceptions of "mental problems" held by "barrio" residents as opposed to those held by traditional mental health programs, particularly in terms of defining "deviant" behavior.
   a. The importance of the peer group (palomia) as a very strong element determining the social behavior of the Spanish-speaking client, throughout both his child-

hood and adult life (los batos, los camaradas).

b. The strong role of religion in the Latino family life and its use as a resource for mental and emotional difficulties.

c. The existence of alternative, well-established curative systems with the "barrio" such as "curanderismo," "espiritismo," herbs and teas used to remedy both emotional and physical ailments.

3. Recognizing the association by the Latino of "mental health" agencies to shock treatments, institutionalization, numerous drugs (chemotherapy), and telling your personal affairs to a stranger.

Clearly, a staff selection process that utilizes these criteria must also provide for participation of the Raza community in every step of the process. When our communities have had the opportunity to voice their needs in terms of staff, it is clear that they place high priority on qualities that reflect sensitivity and tested commitments to Latino values.

For example, in planning for the Chicano Mental Health Training Program in Chicago, community residents envisioned a "humanistic and personal relationship between the therapist and the patient", which involved these characteristics:

1. The services provided by the "helping person" should not only be directed toward the solution of intra-psychic problems, but to the economic, educational and social factors that have contributed to the development of those problems.
2. The "helping person" needs to be as flexible as possible in utilizing the natural supports of family, kin and friends in working with the individual.
3. The therapist should be aware of the techniques which would hinder the interaction between the client and therapist.
4. The immediate attention given to the individual when he arrives at the clinic is an important aspect since this will determine his future attitudes toward mental health. This definitely will fulfill his need for support in his moments of stress.
5. The therapist should be trained to work in developing a familial system of support for the patient. This is very important in terms of the Mexican American's ability to cope with the environmental stress that he faces in the inner city.[17]

B. Indigenous Resource Personnel

It is essential that Community Mental Health facilities begin to use the knowledge and skills of indigenous resource persons who are capable of rendering traditional Latino community services, like curanderos or spiritualists.

In addition, community mental health facilities must begin to use staff, indigenous resource persons who can function in highly productive ways with minimal formal training.

> A practitioner must be acceptable as a person. There must be a feeling that he knows the family so that he can "understand the problem." This is because the Latino family experiences emotional problems collectively and are capable of going to such a practitioner completely open and trusting. Whereas, the Anglo usually goes to therapy with his guard up and his defenses ready.
>
> There are two mental health resources that serve the Mexican American community very well:
>
> (a) *curanderos:* These are the traditional healers of Mexico and Latin America. They still exist in spite of vigorous denials by most Mexican Americans, and are widely used by older Mexican Americans. Because of fear of persecution by police, the medical society and tax agents, they are almost impossible for an Anglo to gain access to.
>
> (b) *mental health ombudsmen:* More important than *curanderos* as mental health resources among Mexican Americans are a group of community leaders to whom people turn with their problems. In some cases these individuals overlap the political leadership as well. Their role at times is similar to the all-understanding ward bosses of the past who were politically important but who also served as a listener, advisor, legal counsel, social worker, and referee for individual and domestic problems of all kinds . . .
>
> They are the people named when you ask a Mexican American the question: "If you had such and such a problem, who would you go to?" All of them are Mexican Americans themselves. They include both sexes. Most have regular jobs, and supply mental health services during their off-hours. None of them would consider accepting payment for their services. Many of them are aware that what they are doing is "psychotherapy" in the Anglo frame of reference. Most of them tend to specialize in certain types of problems.[18]

Currently, such indigenous mental health workers are either completely excluded from mental health service delivery systems, or they are assigned the role of paraprofessional and

used as "casefinders" and interpreters for the professional staff.

The "barrio" wisdom that the community worker brings with him, and his years of experience in providing services to Latino people whom the traditional mental health service delivery system could not, or would not, help—all are ignored and devalued by the professional facility; this is professional*ism* of the worse sort.

It is assumed that the indigenous worker brings nothing to the community mental health facility except his ability to "relate to the community," and thus he must be programmed to reflect the dominant cultural values and norms held by the professionals. The result is that his ability to provide effective services to his community is diminished.

At the same time, while the "barrio" mental health worker is expected to take on the cultural perspectives of the facility, there has been no attempt to provide training for staff that would enable them to understand the cultural perspectives of the client population.

All staff, Latino and otherwise, must have systematic in-service training that will allow them to incorporate Latino values and cultural perspectives in their professional practice.

C. Staffing Procedures Recommendations

All staff levels of Community Mental Health facilities should reflect Latino personnel in proportion to the surrounding Latino population.

The appointment process must insure selection of staff who have demonstrated sensitivity to Latino values and active involvement in the Latino community.

Community mental health staffing procedures must recognize and call for Latino community participation in hiring of staff.

Wherever possible, community mental health facilities should incorporate indigenous resource persons capable of rendering traditional Latino community services; for example, curanderos, spiritualists.

Wherever possible, community mental health facilities should be staffed with indigenous resource persons who can function

in highly productive ways with minimal formal training.

All staff, Latino and otherwise, must have systematic in-service training in order to express values and cultural perspectives in professional practice.

VIII. TRAINING

A growing conviction among Latino mental health workers is that we are dispensing culturally and economically biased mental health services; that is, services that attempt to either acculturate our people or have them defined as "deviant." We are convinced that these services flow out of training settings where mental health professionals are taught theories, techniques and diagnostic procedures which are expressions of the values that support the dominant culture of this society. These values are conveyed in professional practice in ways that either exclude or demean Latino values. All community Mental Health Workers, but especially those who are themselves Latino, should be trained to recognize the psychic, social and cultural realities of the Latino community. These realities must be carefully differentiated from the experience of the dominant society in order for Community Mental Health training to engender co-equality of different cultural sectors within this society. Traditional mental health training has perpetuated the doctrine that culturally different sectors should *acculturate* themselves to the dominant society. The community mental health movement in this country has exposed a lack of cultural pluralism in all of our institutions and this mono-cultural perspective is endemic even in the social sciences and "helping professions" where one would least expect it.

If there is to be hope for change in the training of Community Mental Health (CMH) workers, the transition must begin with the inclusion of values and world views that heretofore have been ignored. Schools and training institutions must lead the way. Included in the term "Community Mental Health Worker" are all pre-professional, professional and nonprofessional human service workers in the community mental health field regardless of disciplinary or experimental background.

Our purpose is to offer a set of recommendations for the training of CMH workers at all levels, so that the above objectives can be accomplished.

These recommendations, including specific proposals for change, reflect the deliberations of the Task Force. Their implementation would insure relevant and usable mental health services for the Latino community.

A. In-Service Training

In planning the content of in-service training, the community mental health facility must look to the community and to Raza social science professionals for the development of an effective training program.

For example, some basic tenets to be included in an in-service training program might be:

1. "Ser servidores, no metiches" (Be of service and not meddlers in family affairs).
2. Learn that because of psycholinguistic differences, certain mental health terminology will be traumatic, or downright offensive to the Latino client.
3. All patients, like all people, prefer to be asked to do things; they react negatively to being told to do it.
4. All patients like to have a choice in the matter (Walk to the treatment center, be taken to it, or be forced by straight jacket device, or law). This can make actual treatment impossible and leaves a very bad taste in the life of the "barrio."

Most important, community mental health staff must learn to respect and make use of the strengths of Latino culture: *el oro del barrio.*

B. Reorientation Of Mental Health Professions

> To say that knowledge is power is one thing. But to say that the authority of professional*ism* rests on something intrinsic to knowledge is superficial. The basis of professional authority is not knowledge itself, but the monopolistic *control of knowledge.*[19]

One means by which social control of minority communities is maintained through mental health practices is indeed the

monopolistic control of knowledge. For too long, the professions have "considered themselves the 'social guardians' of knowledge in the interest of the public good, but have functioned as organs for the social control of knowledge in the interest of the bourgeoisie."[20] Minority communities have witnessed the emergence within the mental health field of the "medical" hierarchy, parallel to the professional structure in the health services in which the physician, by virtue of his exclusive claim to knowledge, dominates every other profession.

Shared power, then, implies shared knowledge. It is imperative that training programs in all areas of mental health be redirected toward the goal of, in Rieff's words, "democratized knowledge."[21]

As we have pointed out above, current training does not point in this direction.

In the program of training for psychiatric residents in community psychiatry, as reported by Zwerling and Rosenbaum, the areas of knowledge necessary for a community psychiatrist were defined as: (1) the dynamics of group process and group therapeutic techniques, (2) family diagnosis and treatment, (3) consultation to community agencies and institutions, and (4) the rudiments of epidemiology and community organization.[22]

There was no indication that psychiatric residents would be expected to learn anything about the culture, values norms and life style of the people they would be dealing with in this predominantly Puerto Rican community. In fact, Zwerling and Rosenbaum's article fails to mention the racial/ethnic make-up of the community at all. The resulting lack of knowledge about cultural factors of the client population would not, however, prohibit the residents from professional dominance in terms of decisions about diagnosis and treatment of mental health problems for Zwerling and Rosenbaum state:

> So long as illness is classified as "mental" and not defined in terms of social pathology the psychiatrist must ultimately deal with an individual mental apparatus.[23]

We do not argue the point that any mental health worker

must, as part of his services, deal with "individual mental apparatus." But we *do* question the relevance to Latino clients of the training that dictates the manner in which psychiatrists, with no knowledge of cultural differences, will work with Latinos. This is clearly an indication of the need for knowledge, moving from the Latino community, up the ladder to the professional training setting.

Social workers, while not privy to the exclusive "secret" knowledge of psychiatrists, have nonetheless taken great pride in their "professional body of knowledge fashioned after the medicopsychiatric model. As a result, they too have failed to acquire or disseminate knowledge relevant to the values and normative behavior of Latinos (and other minorities) that effect mental health.

> The greatest disappointment to Chicanos and other ethnic minorities involved in social work education continues to be the inertia, resistance and paucity of action on the part of schools of Social Work in incorporating ethnic content into their curriculum.[24]

The social work profession, and the other mental health professions, have the potential to play a major role in helping the nation solve the problem of white racism and its effects on the minorities. The following premises are fundamental to any action geared toward relevant social work knowledge, training and practice with La Raza:

1. That the perception ethnic minorities have of the social work profession as "irrelevant" and as an "agent of social control" is based on the reality of their experience.
2. That the stereotyped perception social work has of ethnic minorities is at its best in terms of middle class, Anglo-American theoretical and conceptual frames of reference. Since this perception is based on theoretical constructs developed by researchers and authors foreign or alien to the minority experience and reflecting racial and ethnic bias, it must be corrected by the social work profession and the affected minorities.
3. That the medical and psychoanalytic social work practice model taught in schools of social work with its emphasis on pathology and social disorganization, negates the experience of the ethnic minorities. Their experience reveals to them that while individuals may be "sick" institutions can also be pathological or dysfunctional, if not for the whole society, for segments such as ethnic minorities.

Their experience also tells them that the definition of deviancy is very often a function of power, i.e., who has the power to define whom as deviant?

4. That the values, language, history and culture of ethnic groups are vital determinants of individual and collective behavior. Consequently, their behavior, social competence and experience can only be assessed, conceptualized and understood when these determinants are considered an integral part of the approach.
5. That it is impossible to incorporate ethnic content in the social work curriculum without considering structural changes in the total social work educational system: the model of practitioner the school is educating; redefining the core curriculum; staffing or faculty hiring pattern, classroom and practicum approaches and the pattern of relationship to the ethnic minority communities.[25]

So we see that training programs for the professionals in human services lack the knowledge from the Latino community that they need to produce effective mental health workers.

The paraprofessionals, or nonprofessionals, on the other hand, have community knowledge and need access to research knowledge. We contend that it is only by denying them knowledge in mental health theory, that the mental health institutions are able to use nonprofessional workers in the role of "Judas goat" amidst their communities.

Unless interdisciplinary knowledge, through teaching and research at professional schools, is made available to Latinos, with curriculum that is constructed to be relevant for the Latino (preprofessional students as well as nonprofessional), Latinos will continue to view the training and service delivery systems of the mental health professions as follows:

First, we see that the training in professional schools such as medical schools, schools of psychology, social work, sociology, and anthropology, becomes a restatement of the dominant society's values and norms, stated in professional terms and institutionalized through training and practice.

Thus, it appears that in the professional heirarchical process, the psychiatrist labels as pathological any cultural values and norms that are not aligned with his own.

In turn the social worker is trained to carry on this value-biased training into practice. That practice consists of attempting to "socialize" the Latino into line with the dominant

values. But social workers are expensive and inefficient, since in the majority of cases they are not indigenous to La Raza, whom they practice on. Thus the acquisition of a third party to the culture-biased process of socialization: the paraprofessional, receiving near-poverty wages, trained most often on-the-job, often removed from his own culture and in cultural disequilibrium because he may be attempting to "make it" into the dominant social system. The paraprofessional is used to attempt to acculturate the Latino client. He is ascribed the role of "hustler" to case-find Latino clients for the mental health facility that Latinos do not use. Never does it occur to the mental health professionals that it may be our theoretical constructs, our services and our training orientation which is keeping the Latino from using the facilities.

A recent example of the realization by paraprofessionals that their training must include the acquisition of research knowledge in order for them to effectively deal with the contradiction between traditional mental health training and Latino culture, occured at Lincoln Community Mental Health Center, in the Bronx, New York.

The issue of staff training was a major source of internal conflict in Lincoln's early years. The program of training for the paraprofessionals, designed, of course, by "professionals," visualized them as a group of mental health "aides" who would exist in a sort of "never-never-land," having been separated from their status as community people, but not permitted to move into "professional" roles.

> "nonprofessional" describes what he is *not* but does not clearly indicate what he is . . . he is an amalgam of . . . various roles . . . he is the new marginal man. He must be selected with this in mind, trained and supervised in this fashion, and assisted in forging this new role.[26]

Clearly, the design of training was to maintain the nonprofessional in a marginal role, or non-role.

However, the newly employed nonprofessional staff were not satisfied with a training program that assumed that they could not develop "professional" knowledge and skills:

> Though the first program utilized the socio-economic environment as a teaching tool, it was devoid of courses designed to enhance the

knowledge and skills of the Community Mental Health Workers. These early program attempts were of short duration and lacked the depth and continuity necessary to produce more than superficial results.[27]

Their own perceptions of their potential was not shared by professional trainers as reflected by these comments in an article by a typical trainer:

While nonprofessionals may be selected because of certain characteristics they possess, such as informality, humor, earthiness, neighborliness — in other words some of the "positive" characteristics of the resident population — the other side of the coin cannot be ignored. That is, they may possess considerable moral indignation, punitiveness, suspicion, or they may be so open and friendly on occasion that the significance of confidentiality escapes them. Thus, while the training staff will want to build on their positive skills, to some extent there must be an effort to either train out or control some of these other negative characteristics.

It is most important to note then that NP's are frequently quite competitive with professionals. In essence, many NP's think they are different from the poor and would be more effective than professionals if they had a chance.[28]

Nonprofessionals frequently expect magic from the training process; that is, they expect to learn how to do everything they are supposed to do quite perfectly. To the degree that this is not achieved they blame the training process.[29]

The Lincoln Community Mental Health Center staff did indeed blame the training process, and they spelled out their reasons:

The Lincoln Community Mental Health Center has a history of several attempts at In-service training for the Community Mental Health Workers (CMHW's). None was very successful nor very well received by the CMHW's. Most of these programs were geared either to solving interstaff and interpersonal problems or were conducted as group therapy sessions for people (Mental Health Workers) who did not want or need group therapy.

The above methods emphasized individual worker problems, often times in relation to matters completely unrelated to their job duties, the efficacy, quality and effect of service delivery.

The clerical staff and the professional administrative staff received

no In-service training under the above program. The Psychiatric Interns received training under a specialized program.

All of the early programs were initiated, conducted and evaluated by the professional staff.[30]

In 1969, the in-service training program at Lincoln was combined with career escalation, and paraprofessionals played the dominant role in the planning and implementation for both programs.

The Careers Escalation and Training staff decided to focus the new In-service Program on the socio-political causes of the emotional and practical problems of poverty and the ghetto community, with particular reference to the South Bronx. The format of the courses would no longer be that of the group therapy, interpersonal problem-solving variety as they had been formerly. This new In-service Training Program would focus on the worker and the patient in their class and cultural roles within the context of the American system.[31]

We are heartened by the work of Community Mental Health Workers, like those at Lincoln, who seek knowledge that will enhance their ability to effectively help their neighbors in the Barrio. These workers are indeed the future of the mental health movement, *if* knowledge and power are shared.

The New Careers movement has some forces within it that seek only to be admitted to the fraternity of professions, without changing anything else. There are others within it, however, who recognize that the New Careers movement can be of the most effective forces for the democratiazation of knowledge, that it represents an opportunity to exercise leverage to democratize not just professional structure but professional knowledge as well.[32]

Mental health researchers must also consider democratizing their knowledge, for the effectiveness of any training program is circumscribed by the quality of its body of knowledge.

An evaluation of a community mental health program's child guidance clinic in San Mateo County, California, investigating why many families "dropped out" after their application for service and before the initial interview, did not mention the ethnic/cultural composition of the client population as a factor. It is well known that by controlling the facts that

go into any research project, we can also control the conclusions that emerge.

> History has shown that the professions cannot be entrusted with the social responsibility of being the "guardians" of knowledge. The concept of a "guardian" of knowledge, given our class structure, is not a viable one. The only assurance that knowledge may be used in the promotion of human welfare is that knowledge have no guardians, that it be shared by all of society, and that the professions be charged with the social responsibility of sharing knowledge and be held socially accountable for doing so.[33]

Additionally, all training must begin with the minimum commitment that:

> The training of mental health personnel must be based on the cultural, bi-cultural and bilingual attributes of Raza-Latina people. In order to be effective and relevant, training must take into consideration the fundamental differences in cultural and value orientation between Anglos and Raza-Latino people. This implies considering value orientation or cultural commitments as to: human and interpersonal relationships, time, space and environment, nature and life. Theoretical constructs dealing with concepts such as: la familia, el compadrazgo, salud, curanderismo, espiritismo, personalismo, the roles of man, woman, mother, father, children, son, daughter, abuelos, human and meta-physical (trans-human) "healing" or treatment, must be incorporated in viable training programs.
>
> The traditional staffing patterns, i.e., utilization of highly trained professional personnel, should be assessed in terms of the possible utilization of the treatment "wisdom" available among Barrio people, i.e., "Barrio professionals."[34]

Chicano social work students at San Diego State University School of Social Work have defined the problem in terms of three priorities:

> 1. *Relevance*. The "world" that is presented to our people at pre-college, undergraduate levels of education does not adequately relate to our own historical and immediate experience. The academic presentation of this "world view" is often characterized by two attitudes toward our people: hostility and benign neglect. Our education should involve the positive study of our cultural heritage, linking that cultural experience to a social paraxis, the dialectical interchange and synthesis between social theory and practice.
>
> In this sense, the notion of relevance in social work curriculum per-

forms a vital function for schools of social work. Social work theory and practice has been eulogized for a long time in a historical, philosophical terms by the social work profession as dedicated to "self-actualization," "individual freedom," "democratic processes," and "human and social enrichment." These terms represent rhetorical aspiration more than realistic achievement. But since they are claimed as core values of the social work profession, the profession itself is challenged constantly to achieve those goals in practice. Is it not obvious that the schools of social work should begin to practice their professional commitment to culturally-pluralistic models for social work education and practice by supporting Chicanos in their work to build Chicano-related social work curriculum within these same schools?

2. *Socialization.* Our training should be a culturally-authentic socializing process, nourishing and enhancing our ethnicity and indigenous character. Too often in the past Chicanos have been pressured ~~to~~ accomodate to alien thought-processes and behavior patterns in order to complete their education. The pressures have been exerted by field work instructors, classroom faculty, the grading system, and the rewards-and-punishments procedures of the school. As a consequence, behavior has tended to become totally goal-oriented and degree-oriented, regardless of psychic and social liabilities. We seek to avoid any danger of being neutralized by our extensive participation in the social work educational process to such an extent that we would return to our community as ideological and insensitive strangers.

3. *Competence.* We should receive . . . the necessary practice skills to interpret our social world and to act upon its relationships with other social worlds. These skills should not be narrowly circumscribed into distinct and autonomous knowledge bases and methods of practice; rather, they should be inter- and multi-disciplinary in character and oriented toward social action and social change, preparing us for sensitive perception, intellectual comprehension, and flexible intervention in the social concerns of our community.[35]

Finally, the mental health profession must use its influence to assure that all training of paraprofessionals be directly related to institutions of higher learning, at which all paraprofessionals being trained can also be enrolled to do accreditable course work. It must lastly commit itself to accepting experience credits gained by paraprofessionals in mental health programs.

If the profession's educational institutions, e.g., schools of medicine, graduate schools of social work, psychology and soci-

ology, ever hope to be able to train mental health problems of La Raza, each must make a determined effort to establish a parallel training program with their facilities and curricula to include a full complement of Latino faculty and students. In the selection of faculty the professions must take advantage of the vital contribution that the bilingual/bicultural Latino professional, who still has his roots in his culture, can provide.

The resulting encounter in the training setting, if the Latino is represented in appropriate numbers, will be the crucible within which the mental health professionals will develop a theory relevant to and comprehensible by Latinos. This exercise will produce a clear understanding of what is merely a different set of values and different cultural practices. This in turn will result in research, therapeutic skills and training methods that will be of value to Latinos.

This responsibility has been acknowledged:

> Community psychiatry, as I would define it, involves the utilization of the techniques, methods and theories of social psychiatry and other behavioral sciences to investigate and to meet the mental health needs of a functionally or geographically defined population over a significant period of time, and the feeding back of information to modify the central body of social psychiatric and other behavioral science knowledge.[36]

We see as crucial the following basic functions in further dispensing the responsibility that the mental health profession has to Latinos:

> (1) *Expanding Function:* To provide the mental health profession with alternative theoretical frameworks which will be capable of accurately assessing the mental health or illness of La Raza by theories that are attuned to the socio-cultural realities.
>
> An objective application and longitudinal basic research documentation to assess the efficacy of the culture-conflict theory model of mental illness currently being proposed by Latino professionals.

The mental health needs of Latinos can be met by the mental health profession's training schools only if the training of Latino preprofessional and paraprofessionals includes curriculum for the development of theoretical constructs consistent

with the socio-cultural factors impinging on the Latino community and determine its mental health or illness.

Dieppa poses the problem thusly:

> For some of us, further discussion of ethnic minority content sounds like rhetoric. For others, it may represent a challenge or threat to the closely guarded eternal and sacred truths of social work theory and knowledge. There may be those who view the sincere attempt of the minorities to enrich the social work curriculum by incorporating vital theoretical and practice constructs as premature, lacking a sound research foundation and conceptually untenable. There are those among us who feel the expediency of adding some ethnic content without basically altering the social work educational structure. Others may feel uncomfortable, anxious, unsure about venturing in areas of theory and knowledge foreign to their area of expertise or practice.
>
> There is the expectation members of the ethnic minorities should provide definite theoretical constructs, well developed conceptual frame of references and usable research findings in an area of knowledge which remains neglected.[37]

Other functions for professional schools, served by the inclusion of Latinos on faculty, research on theoretical alternatives, and Latino socio-cultural content, are further defined by Dieppa:

> (2) *Sensitizing Function:* To sensitize Anglo students as well as other students, to the cultural, psycho-social and historical attributes of our Chicano population, as well as the problems they face as a result of socio-economic forces and the institutional racism which permeates our society. Through this function it is hoped that students will be helped to overcome racist attitudes through the acquisition of new knowledge and modification of human values and to enhance their skills in working with the Mexican American population. This function will seek to at least minimize or reduce the negative impact the Anglo or white practitioner will have on the barrio people.
>
> (3) *"Filling the Gap" Function:* It Is Hoped That The Enrichment Of The Social Work Curriculum By Incorporating Chicano Content And Other Developments, Will Help To Correct The Inadequacies Of Existing Courses And Curriculum.
>
> (4) *Psychological Function:* The introduction of Chicano content in the regular sequences or curriculum, as well as the offering of "ethnic" types of courses, will provide an anchorage for a sense of identity

and pride to the Mexican American student. Identity not only in relation to his "Raza" or ethnic group, but also in terms of the social work profession and its concern for his people.

(5) *Function of "change":* The enrichment of the social work curriculum with its inherent and indispensable participation of Chicano students and Chicano faculty, will hopefully result in the eventual change in the school's curriculum. It is hoped that the mission of the school and the model of practitioner trained by the given school, will change in keeping with the needs of the Chicano population to be served or reached.[38]

C. Alternative Training Methods

One alternative by which professional schools can achieve effective mental health training and research for all levels of mental health workers which will relate to the needs of Latinos could be through a determined and comprehensive effort on the part of professional training institutions to establish, within their facilities, parallel training programs which provide for professionals and paraprofessionals:

1. Co-joint training facilities and curriculum units.
2. An interdisciplinary student body, including paraprofessionals, undergraduate students, graduate students and psychiatric residents.
3. Interdisciplinary faculty and administration, with bilingual and bi-cultural Latino professionals and paraprofessionals in appropriate numbers.

Within such a setting, we propose the creation of a parallel training process for paraprofessionals and community workers, leading to a practicum degree in mental health, at the professional level, which would designate its graduates as "Master of Mental Health Services." Within this model it will be possible to provide the interaction and exchange of knowledge/wisdom that is so clearly needed between mental health "professionals" and the Latino community they serve. In this way we can establish linkeages between the two levels of mental health workers, and provide a point of entry into truly relevant training for the Latino community worker.

Other avenues to more effective total mental health training, which must be given serious consideration by the professional institutions, include:

1. A special in-service training curriculum for clerical workers and workers other than community mental health workers.

2. Specialized in-service training for administrators and supervisors.

3. On-the-job training which has no avenues for credentialization of community workers must be regarded as inappropriate and unacceptable for funding.

We are encouraged by the development of programs like the Chicano Mental Health Training Program in Chicago where formal links with the University of Chicago Medical School have been established and creditation is planned. It is disgraceful that there are so few programs like these addressing themselves to relevant training for community workers.

4. Programs which combine training with service delivery and include career escalation must be encouraged. The staff-determined guidelines for the Lincoln Community Mental Health Center can provide a mode for beginning Programs:

(a) Negotiating for full New York State Department of Higher Education recognition and accreditation for the In-Service Training Course.

(b) Liaison and affiliation on an ongoing basis with Hostos, the local community college, and New York University, so that In-Service Training courses given at Lincoln would be fully credited . . . also an arrangement where Hostos students could attend Lincoln seminars and Lincoln students attend Hostos. We are now serving as consultants for Hostos planners who are designing a mental health major for their students.

(c) Consulting with the New York University administration in the planning of a four-year program offering a major in community mental health.[39]

5. Several graduate schools of social work, including the University of Michigan and Wayne State University have begun to admit candidates for the Master's Degree without a B.A. being required. These efforts have thus far been very minimal and must be greatly expanded and adopted by other schools.

6. The establishment by professional schools in Raza communities of Training/Service centers, like the one in operation

in East Los Angeles, and the Barrio Learning Center planned for Detroit, are a positive step toward providing relevant research and education within the Barrios. But these programs represent only gestures; we need full-scale and national action.

7. The professional schools must begin immediately serious and large-scale recruitment drives to attract Latino students and faculty.

8. The development of barrio-based field work placements provides us with the challenge and opportunity to enrich the curriculum, while at the same time beginning to make practice relevant.

9. The professional schools can enrich their curriculum by developing a positive working relationship with Chicano Studies programs.

10. Schools must assume the fundamental responsibility for funding Chicano recruitment programs.

11. Chicano students, faculty and Chicano professional and community organizations should carry out the planning, development and implementation of Latino recruitment programs.

12. Latino students, faculty and community people should participate on admissions committees in the schools, reserving to them the final decision on the admission of Latino candidates.

13. Recruitment, admissions, and retention programs must guarantee student financial aid to complete programs of study leading to professional degrees.

14. Recruitment programs and strategies for Latino faculty must be an integral part of the training process.

15. Latino faculty must possess academic tenure and economic security at pay levels equitable with competitive pay scales in practice. They must be guaranteed the time, resources and responsibility to work in the following areas:

a. research and develop Latino-related curriculum
b. counsel and advise Latino students
c. contribute consultant and planning services to the Latino community.
d. develop relationships with the Latino community for the

exchange of information related to school activities and for facilitating the maximum community input into academic and field programs.

16. Allocation and distribution of Latino faculty workloads should be related to their interests and skills and maintain equitable balance among their different responsibilities for classroom and field instruction, research and collaborative relationships with the Latino community.

17. Latino faculty must be assured advancement in all echelons of the administrative and educational operations of the school.

18. Instructional services from barrio people must be retained as integral components of the teaching profession, and, consequently, should be institutionalized within the school; such as the "Barrio Professor" concept developed Worden School of Social Work Services at San Antonio, Texas.

D. Curriculum

In terms of the study and research into theoretical constructs, curriculum must be expanded to develop conceptual frameworks relevant to Latinos. In developing a training curriculum, two specific systems must be emphasized, one cultural; the other social, including the following technique: a highly organized teaching or learning unit in compact form should contain its own educational objectives.

As an example, the type of training curriculum should include essential components such as: the heritage of the Latino individual, the family, the Latino community and its social structure. Under the individual and his heritage could be explored the meaning of bi-culturalism; under the family could be explored the cultural values to which the Latino family relates. The Latino community should be studied as an internal economic and political colony within the United States system.

The pattern of curriculum described above could carry similarly into other important components beyond heritage, and include such contributions to the Latino character as identity, life style and values and coping devices. Also, a number of modes of interaction could be introduced when studying the

individual, the family, the community and the Latino society. Thus, the training elements in training Barrio mental health workers should contain the following definite ingredients; educational objectives (statement of intended learning outcomes), training materials (used in instruction, reading bibliographies, cassettes, films, cases), training methodology (statement and descriptions of techniques to be used in teaching), and evaluation (methods to be used in evaluating the achievement of educational objectives).

The socio-cultural realities and needs of Latinos dictates that the approach of a training curriculum for Barrio mental health must be developed and founded upon a set of value assumptions about the Latino community and its interfaces with the dominant culture, including those institutions which are indigenous to American society, yet not excluding other perspectives which benefit the common good.

It must be taught that the Latino culture is the synthesis of socially distinct cultures (the Indio-Afro-Hispano and the Anglo-Saxon). The Latino United States citizen incorporates and synthesizes attitudes from the Latino and Anglo cultures in such a manner that the result is the emergence of a new culture, unique and distinct from the Latino and Anglo cultures. The culture therefore, provides its members with all of the attributes of a culture. Latinos are neither culturally disadvantaged nor culturally deprived. The culture of the Barrio is dynamic (in a constant state of synthesizing); it is heterogenous (synthesizing at different rates); it is viable (mixing in a productive manner). The training of mental health workers should consider that the Latino culture exists in spite of and in an environment which does not foster its development, which is, in fact, in many areas, hostile toward its development. Thus the hostile environment is detrimental to the psychic well-being of the members of the Latino culture. Yet, the negative impact of the hostile environment is to some degree offset by the positive impact of the Latino culture.

E. Training Recommendations

Professional schools must be staffed by sufficient numbers of Latino professionals, from all disciplines, to ensure system-

atic study of Latino culture by future community mental health workers.

A. The entire professional curriculum must systematically include the study of Latino values and cultural perspectives.

B. The curriculum must include systematic study of the distribution of power and resources within the Latino community as well as between the Latino community and the larger society.

C. Schools that train community mental health workers must provide practicum and internship experiences for students, Latino and others, in facilities where they will have intense interchange with Latino clients.

D. Latino faculty and students must be encouraged, supported and rewarded for conducting research and rendering services as defined by the self-perceived needs of the Latino community.

E. Professional schools must give particular importance to the creation of new intervention techniques specifically designed for the Latino.

F. Accreditation boards must contain Latino professionals to insure implementation of recommendations of this task force.

IX. RESEARCH

We deal now with research, since it is the backbone of any training program. Research in mental health has not been initiated around any relevant study on the mental health of Latinos. Basic research is nonexistent in: longitudinal study of the validity of traditional mental health theories; objective cross-cultural studies in crucial areas such as cognition, relationship of field dependent vs. field independent characteristics to learning; Latino social behavior and perception differences vis-a-vis the dominant society; the objective study of the totality of Latino values and norms, which affect behavior, and thus influence mental health.

Instead the majority of the research being supported is applied research, which serves to invalidate the Latino by documenting the existence of values and norms among us which have been defined as deviant by mental health theories, and which basic research has not yet validated as pathological.

Professional education schools, in their research and training, have a responsibility to the communities they serve in: (1) the acquisition and dissemination of knowledge through research that presents all of its communities in objective fashion, and (2) the training of mental health workers that can relate totally with each community they serve. The effort has to be in assuring that research and training are both two-way streets, and that there must be consumer input into both.

That professional education schools have abrogated these responsibilities to the total community is very well stated by Rieff:

> Every professional occupation includes a large component of nonprofessional knowledge and technology in its professional practice — intuition, common sense, folkways, and cultural and moral values. There is no reason to believe that professionals are more effective or better equipped in their use of this nonprofessional knowledge and skill because of their more professional (i.e., estoric) knowledge. In fact, they tend to organize their use of nonprofessional knowledge and skill for their own purposes rather than the client's. They aggrandize nonprofessional knowledge, pretending to have a much greater range of professional estoric knowledge and skill than, in fact, exists.[40]

Latinos at the 1972 Chicago Conference on "Mental Health and the Spanish Speaking: Implications for the Decade Ahead," state some of the more specific research issues:

1. The literature overall is self-contradictory in that:

   (a) in-group culture factors are held, and are not held as accountable for Spanish Speaking population mental health problems; and
   (b) upward mobility within the dominant Anglo-American socio-economic class status criteria is held, or is not held as accountable for Spanish Speaking population mental health problems.
2. The data is fragmented, quantitatively lacking, of low or dubious reliability, or culturally ideologically biased in both theoretically biased in both theoretical presumption and methodological practice.
3. The intuitive insight and empathetic grasp, real and potential, of Spanish Speaking social scientists of substantive and methodical solutions in the study of Spanish speaking population mental health problems has barely begun to be encouraged or exploited, and for certain subgroups of Spanish speaking population, e.g.,

Puerto Ricans, almost no in-group social scientist representation occurs.

4. The uninstitutionalized resources of Spanish-speaking population for coping with in-group mental health problems are positive.
5. Repressive and discriminatory dominant Anglo American institutionalized controls contribute most to both in-group and out-group Spanish-speaking population deviance.
6. The propensity of Spanish-speaking population for pragmatic solutions encourages their acceptance of common sense activity in the area of dealing with mental health problems.
7. Ethnicity per se is a "classic" social behavior variable, and "Chicano" or "Mexican American," "Puerto Rican," etc., are major ethnic (cultural) groupings in the United States.
8. The ideological norms of the institutions under Anglo American culture grouping dominance can be isolated as causal in effecting repressive and discriminatory social controls and in stimulating deviance among Spanish speaking population.
9. The ideological norms of the Anglo American culture group generally can be isolated as accountable for conflict situations among subgroupings of Spanish-speaking population, and between Spanish-speaking and dominant Anglo American populations.[41]

Research Recommendations

A. Involve Latino faculty, students and community people in the planning and implementation of any mental health research in the barrios.

B. Take immediate steps to conduct longitudinal, basic research on the applicability and further refinement of the culture-conflict theory.

C. Motivate Latino professionals to undertake basic research on the validity of traditional mental health theories (e.d., intrapsychic theory) for Latino mental health treatment.

D. Conduct in-depth cross-cultural studies related to such phenomena as cognitive styles and field-dependent vs. field independent modes of learning.

E. Undertake objective studies of Latino social behavior and perceptions vis-a-vis the Anglo American.

F. Perform in-depth study of Latino concepts of health, illness, barrio helping systems and the totality of Latino cultural values and norms.

X. ACCREDITATION

We urge the mental health professions, professional schools, the accreditation bodies from these professions, and NIMH, to insure that all future accreditation teams include Latino bi-cultural professionals, who are cognizant of, or are active in the development of alternative theoretical concepts vis-a-vis the assessment of mental health or illness of Latinos and who are fully aware of the socio-cultural organization of Latinos in this society by virtue of the unique psychic and socio-cultural-historical experience.

In addition, we present the concrete and specific efforts of Chicago's Chicano Mental Health Training Program as an example of the beginnings that can be achieved with a commitment to do so:

> The emphasis on continuing education is to maintain continued contact with the trainee so that further education and training of the individual can take place, while at the same time the graduate can make significant contributions back to the Chicano Mental Health Training Program. This will be accomplished in the following ways:
>
> 1. The establishment of seminars and discussions among graduates and trainers concerning problems they face in their job situations.
> 2. Continuing course work on advanced therapeutic techniques that are directly relevant to their responsibilities and therapeutic tasks. These additional courses will also be accredited by the City College system and will apply to both their 2-year and 4-year degrees.
> 3. Every effort will be made to encourage graduate trainees to do advanced academic work in 4-year colleges and graduate schools. Relationships will be developed with a variety of universities and educational programs which can meet the future needs of graduate trainees.
> 4. We feel that the graduate trainees have a great deal to contribute to new trainees coming into the program and to the development of the program in general. To maintain this relationship, every effort will be made to utilize graduate trainees in the on-going program by:
>   a. having graduate trainees act as advisors to the new trainees.
>   b. having selected graduate trainees sit in an advisory capacity to the general program.
>   c. having selected graduate trainees act as trainers on specialized subjects.
>
> As a result of negotiations with the Chicago City Colleges and several

4-year universities in the Chicago area with whom we have been working, we have developed a system for full accreditation for the curriculum of the Chicano Mental Health Training Program (CMHTP) and channels for higher education for our trainees.

The base of accreditation and support for the CMHTP will come from the Chicago City College system . . . This support includes:

1. A series of courses from the college's approved curriculum in social service, which closely parallels the curriculum of the CMHTP, have been selected.
2. These courses will be taught by faculty selected by Chicano Mental Health Training Program staff.
3. Courses will be taught at the Latin-American Youth Center.
4. The courses will be offered to Chicano Mental Health Trainees only.
5. The courses will emphasize basic content as developed by the college, as viewed from the Chicano experience.
6. These courses will satisfy requirements toward the Associate of Arts degree.
7. Approval and support for the team teaching concept utilizing non-academic experts.
8. Those non-academic experts who are enrolled in the City College will receive academic credit for their participation in the training.

These courses will be transferable to 4-year institutions in the Chicago area. A full agreement for transference of all credits has been worked out between the Chicago City Colleges and Roosevelt University . . . We are currently approaching a similar agreement with Chicago State University and forsee no difficulties in establishing similar agreements with other institutions in the Chicago area.[42]

XI. OVERALL RECOMMENDATIONS TO NIMH

We conclude our report to this Conference with a set of recommendations that this Conference should endorse and which NIMH hopefully will accept in order that Latinos in this country will begin to have their mental health needs attended to.

1. Fund pilot projects to train bi-cultural/bilingual staff for positions throughout NIMH.

2. Recruit Latinos for internships and fellowships within the Institute, in order to spur the development of alternative theoretical constructs relevant to the mental health problems of the Latino community.

3. Provide incentive stipends to attract Latinos into the mental health field.

4. Extend the use of staffing grants mechanism to facilitate the writing of training proposals for Latino para-professional personnel in professional schools, for communities who do not have the necessary resources.

5. Give a high priority in granting proposals for the training of native Latinos in the fields of mental health.

6. Accept the qualifications as set and defined by the Latino people who sponsor any training programs as the criteria for those servicing these programs.

7. Establish a reciprocal agreement concerning certifications between Puerto Rico and all states regarding mental health professions, in order to enhance and increase manpower and training resources and potentials of the Latino communities.

8. Focus attention on the following in relating the Civil Rights Act to the Latino community:

a. Develop a training curriculum relevant to the Latino.
b. Recruit Latino faculty.
c. Recruit Latino students into training programs.
d. Develop a practicum relevant to the Latino.

9. Develop a two-pronged "crash program" to increase Latino manpower in mental health fields with 15 percent of Manpower and Training budget set aside for this purpose.

10. Establish and fund demonstration training centers to serve as models for integrating training, service, and research aspects of manpower.

11. Offer training to non-Latino individuals working with Latinos in mental health fields in order that they may understand the special problems and needs of the Latino. Offer such training under the direction and implementation of Latino personnel and consultants.

12. Insure the inclusion of Latino people in programs funded for minority continued education.

13. Establish an annual planning Conference on Mental Health and the Latino, to assess research, training and services, and to make recommendations for the following year, and to monitor the progress of any affirmative action plan.

NOTES

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